AGENDA

1315  1. Apologies for Absence  Pauline Quinn
1317  2. Declarations of Interest All
   To declare any interests specific to agenda items
1319  3. Minutes of Previous Meeting Pauline Quinn
   To approve minutes of the meeting held on 22 March 2016.
1322  4. Matters arising and review of outstanding actions Pauline Quinn
   To note and review outstanding issues.
1325  5. Primary Care Contracts/Performance Monitoring Caroline Procter
   To receive and note a report from the Co-Commissioning Manager of
   Ipswich and East Suffolk CCG (JCC 16-06)
1330  6. Care Quality Commission (CQC) David Brown
   To receive and note a report from the Deputy Chief Operating Officer,
   Ipswich and East Suffolk CCG (JCC 16-07)
1335  7. Ipswich Practices Claire Pemberton
   To receive for comment an update from the Commissioning
   Implementation Manager, Ipswich and East Suffolk CCG (JCC 16-08)
1350  8. Primary Care Transformation Fund Caroline Procter
   To receive and approve a process for selection from the Co-
   Commissioning Manager, Ipswich and East Suffolk CCG (JCC 16-09)
1355  9. PMS Development Framework Caroline Procter
   To receive and note a report from the Co-Commissioning Manager,
   Ipswich and East Suffolk CCG (JCC 16-10)
1400 10. The Future of Primary Care (NHS England 5 year Forward View) Stuart Quinton
   To receive and note a verbal report from the Suffolk Primary Care
   Contracts Manager, NHS England
1410 11. Vulnerable Practice Fund Stuart Quinton/David Brown
   To receive and note a verbal report from the Suffolk Primary Care
   Contracts Manager, NHS England
1420  12. **Self-Certification Process (Setting out Co-commissioning Assurance Process)**  Caroline Procter (JCC 16-11)

To receive and note a report from the Co-Commissioning Manager, Ipswich and East Suffolk CCG

1430  13. **Date and Time of next meeting**

2.00pm – 4.00pm, Tuesday 26 July 2016, Kesgrave Conference Centre, Twelve Acre Approach, Kesgrave, Suffolk, IP5 1JF

14. **Questions from the public – 10 minutes**

The Committee welcomes questions on any item on the meeting agenda. In order that meetings start and finish on time the Chair will manage the time available to ensure that all contributions can be heard.

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**Exclusion of the Press and Public**

The Joint Commissioning Committee is recommended to exclude representatives of the press, and other members of the public, from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; Section 1(2), Public Bodies (Admission to Meetings) Act 1960.
Meeting of the NHS England/Ipswich and East Suffolk CCG Joint Commissioning Committee held on Tuesday 22 March 2016, in public, at Kesgrave Conference Centre, Twelve Acre Approach, Kesgrave, Ipswich, Suffolk

PRESENT:
Pauline Quinn Lay Member: Patient and Public Involvement, IESCCG (Chair)
Carolyn Larsen Head of Commissioning, NHS England
Ed Garratt Chief Officer, IESCCG
Dr Lorna Kerr Secondary Care Doctor, IESCCG
Graham Leaf Lay Member: Governance and CCG Vice Chair, IESCCG
Stuart Quinton Suffolk Primary Care Contracts Manager, NHS England
Dr Mark Shenton Chair of Ipswich and East Suffolk CCG
Matthew Thorpe Head of Finance (Direct Commissioning), NHS England

IN ATTENDANCE:
David Brown Deputy Chief Operating Officer, IESCCG
Jo Mael Corporate Governance Officer, IESCCG
Caroline Procter Co-Commissioning Manager, IESCCG

16/13 APOLOGIES FOR ABSENCE
Apologies for absence were noted from:
Maddie Baker-Woods Chief Operating Officer, IESCCG
Carl Goulton Chief Finance Officer
Cllr Alan Murray Chair, Health and Wellbeing Board
Jan Thomas Chief Contracts Officer
Andy Yacoub Chief Executive, Healthwatch

16/14 DECLARATIONS OF INTEREST
Dr Mark Shenton declared an interest as a GP within the Ipswich and East Suffolk area and holder of a personal medical services (PMS) contract.

16/15 MINUTES OF PREVIOUS MEETING
The minutes of the previous meeting held on 26 January 2016 were approved as a correct record.

16/16 MATTERS ARISING AND REVIEW OF OUTSTANDING ACTIONS
There were no matters arising and the action log was reviewed and updated.

16/17 2016/17 NEW GP CONTRACT
The Committee was in receipt of a report from the Suffolk Primary Care Contracts Manager, NHS England which outlined key changes to the GMS
(General Medical Services) contract in England due to take effect on 1 April 2016.

Every year, contract negotiations took place between NHS Employers (on behalf of NHS England) and the BMA’s General Practitioners Committee (GPC) on amendments that would apply to GMS contractual arrangements for the following financial year. Agreement had been reached in respect of the 2016/17 financial year the detail of which had been announced on 19 February 2016.

2016/17 changes continued to deliver on public commitments made as part of the Five Year Forward View to make additional investment in primary care, and build on the previous year’s extensive changes. The aim was to help alleviate some of the pressures in general practice and to improve access to services.

Key changes to the GMS contract for 2016/17 were appended to the report and summarised within paragraph 3.2. The changes also applied to Personal Medical Services (PMS) contracts.

Detailed guidance on all of the agreed changes together with links to the supporting legislation and standard contract documentation was to be published on NHS England’s dedicated GP contracts page.

The Committee was advised that, whilst it was proposed that a maximum indicative rate would be set in respect of payments to locums, any practice wishing to exceed the maximum rate could make notification to NHS England.

Having noted that the report stated that the dementia enhanced service was to cease it was explained that, the enhanced service had ceased as a result of the dementia service now being seen as ‘business as usual’.

The Committee noted the content of the report.

16/18 PERSONAL MEDICAL SERVICES DEVELOPMENT FRAMEWORK REFRESH

The Committee was in receipt of a report which sought to provide an update on progress made with refreshing the Personal Medical Services (PMS) development framework.

The Committee was reminded that, at its meeting on 26 January 2016, it had been informed of the proposed approach to refresh the Personal Medical Services (PMS) Development Framework for 2016-17. The Committee had endorsed that approach and agreed that once the Framework had been finalised, it should be circulated to the Committee for approval so that it could be in place for 1 April 2016.

Since the previous meeting, the CCG had identified potential revisions to the Framework following discussions with internal colleagues; Clinical Executive; the Local Medical Committee (LMC); the Local Medical Committee’s Liaison Group; Public Health and NHS England. NHS England had advised that in accordance with the existing Suffolk PMS Agreement, there was a contractual requirement for a ‘PMS Agreement Review Committee’ (PARC) to meet and consider/agree any changes to the Development Framework. As a result, a meeting of the PARC was held on 11 March 2016, at which the LMC’s response was discussed.

The LMC had raised concern with some of the proposed Framework changes and intended to hold a virtual meeting of its PMS sub-committee week commencing 14 March 2016 in order to consider the CCGs’ response, prior to reconvening the PARC.
As a result of the above the Joint Commissioning Committee was not able to ratify the final Framework at today's meeting and it was being proposed that, after final agreement by the PARC, the Framework would be published to all PMS practices before 1 April 2016, with the caveat that it remained subject to ratification by the Joint Commissioning Committee.

It was then intended that a further (virtual) meeting of the Joint Commissioning Committee be arranged as soon as possible, following final agreement at the PARC, to ratify the Framework.

Members of the Committee noted the content of the report and endorsed the proposed course of action.

16/19 LOCAL ENHANCED SERVICES (LESs)

The Committee received a report from the CCG’s Co-Commissioning Manager which provided an update regarding proposed changes to the CCG Primary Care Local Enhanced Services’ (LES) Contracts. A copy of the 2016/17 LES summary was appended to the report.

The current position was that;

- There were currently 17 Local Enhanced Services' contracts (eight specifically for GMS practices) that were in addition to the standard GP contract and now formed part of the NHS Standard Contract.
- The majority of 2015/16 LES's had been carried forward into 2016/17. Modifications had been made to the Prescribing Incentive Scheme and Collaboration LES’s.
- The CCG intended to extend the multi-disciplinary team LES until June 2016 only whilst redesign options were being considered.

Following approval of the PMS Development Framework, to which the GMS only LESs were linked, all the LESs would be shared with practices, expressions of interest collated and the NHS standard contracts drawn up.

The Co-Commissioning Manager clarified that the Chronic Obstructive Pulmonary Disease (COPD) Inhaler Switch service was not being continued in 2016/17 and, as such, should not have been included on page 4 of the appendix.

The Committee noted the content of the report.

16/20 PRIMARY CARE CONTRACTS/PERFORMANCE MONITORING

The Committee was presented with a report which provided an update on;

- List Closures
- Personal Medical Services (PMS) Dashboard
- Premises Funding – Primary Care Transformation Fund
- Prime Ministers Challenge Fund Centre

Key points highlighted during discussion included;

**List Closures**

Only one practice, Combs Ford currently had a closed list although it was likely that further applications would be received. NHS England had in place a formal process in respect of practice list closures which incorporated consultation with
neighbouring practices, and required practices to provide patient feedback and have an action plan in place to address the situation. It was intended that the Joint Commissioning Committee would have responsibility for decisions in respect of list closures going forward.

Having considered the best way of facilitating effective decision making in respect of list closure applications the Committee agreed that face to face meetings should be convened with members of the Committee being able to telephone into the meeting if necessary.

**PMS Dashboard**

The overall performance of local practices had been reviewed jointly by the CCG and NHS England and, overall, the position remained good. Since the last meeting a number of metrics had been updated and the position remained largely similar with one minor exception:

- Prescribing within 5% - 12 PMS practices were over spent by more than 5% of budget which was a slight improvement from the previous month.

Prescribing issues had been taken up collectively and individually with the practices concerned. It should be noted that the proposed tolerance on the prescribing budget within the PMS Development Framework would be revised from + or – 5% to achievement of budget.

**The Committee endorsed** the approach.

**Premises Funding – Primary Care Transformation fund**

NHS England announced that the £250m per year Primary Care Transformation Fund would be prioritised locally by CCGs prior to being processed by NHS England. National guidance on how those monies would be managed was delayed. In the interim the CCG had written to practices to alert them to the potential capital funding route and to start planning schemes that they might wish to develop. A range of criteria had been circulated to inform planning within practices.

As national guidance was not yet available the deadline for submissions had been deferred by NHS England from the end of February to the end of April 2016. It was anticipated that the Joint Commissioning Committee would be responsible for approving the prioritised list of schemes.

**The Committee endorsed** the proposal for it to be responsible for the approval of prioritising the list of schemes.

**Prime Minister's Challenge Fund Centre**

The Prime Ministers Challenge Fund was initiated to support local health economies with putting in place schemes that would enable primary care to work at scale to provide general practice services in the evening and over the weekends. The Suffolk GP Federation had worked with both Suffolk CCGs to develop a successful bid and the scheme had been resourced for an initial one year period. An announcement on the future funding of the scheme was expected in the near future.

The **Committee noted** the content of the report.
16/21 CARE QUALITY COMMISSION (CQC) INSPECTIONS

The Committee was provided with an update on the current status of recent CQC inspections of Ipswich and East Suffolk CCG’s GP practices which were detailed within paragraph 3.1 of the report.

The CQC’s reports, to date, had indicated that the quality of primary care services in Ipswich and East Suffolk was “good”. Inspectors had not identified any whole scale areas for improvement but had highlighted some individual needs and opportunities for improvement.

Detail on the inspections and ‘next steps’ was set out within Section 4 of the report.

The Committee noted the content of the report.

16/22 VULNERABLE PRACTICES

The Committee was advised that nationally NHS England had identified funding of £10m to support practices identified as being ‘vulnerable’ in line with its published criteria.

In light of the above, Ipswich and East Suffolk CCG had carried out an exercise to identify such practices which had resulted in six applications for funding having been submitted. One of the six applications had been a combined application on behalf of Ipswich practices.

It was noted that practices making submissions would be required to provide 50% of any funding required although there was likely to be flexibility or a phased approach in relation to receipt of the funding.

Although it was noted that communications were to be issued to practices in the near future seeking agreement to them being put forward for the funding, those practices identified by Ipswich and East Suffolk CCG had already been made aware that submissions had been put forward.

The funding was being made available to assist with development and support for the practices concerned which could include making time available to practice staff to facilitate turnaround work. The opportunity for practices to work with patient participation groups was emphasised.

The Committee noted the verbal report.

16/23 DATE AND TIME OF NEXT MEETING

Although the next meeting was scheduled to take place from 2.00pm – 4.00pm on Tuesday, 24 May 2016, at Kesgrave Conference Centre, a possible rescheduling of the CCG’s Governing Body meeting might necessitate a change of date and venue.

Meetings of the Committee were advertised in the local press and papers published on the CCG’s website.

16/24 QUESTIONS FROM MEMBERS OF THE PUBLIC

1) Having questioned what opportunities existed for members of the public to question the CGG it was explained that, as well as having the opportunity to
attend these meetings and those of the CCG’s Governing Body, members of the public were welcome to email the Chair of the CCG via the CCG website, and submit written questions. The CCG’s strong commitment to involve patients and members of the public was emphasized.

2) A number of questions were received in relation to mental health service provision which, whilst not on the agenda, had been discussed at the CCG’s Governing Body meeting held that morning. Questions were in relation to the sale of St Clements Hospital, and the content of the Care Quality Commission’s survey in relation to Norfolk and Suffolk NHS Foundation Trust. The Chair agreed to provide email details to the member of the public concerned in order that questions might be received for forwarding onto the relevant individual within the CCG for response.

3) Having been advised of the difficulty caused for members of the public by the use of unexplained acronyms, the Committee agreed that a glossary similar to that developed for Governing Body meetings would be made available for future meetings.

4) Having questioned whether patients registered at practices identified as ‘vulnerable’ were aware, it was explained that although patients might be experiencing access delays it was likely that ‘vulnerability’ was not apparent to patients and did not affect services received. The role of Healthwatch in gaining patient views in relation to practices was highlighted.

5) The appropriateness of the CCG’s recent ‘tweets’ in relation to preparation for Easter was questioned. It was explained that paracetamol was one inexpensive product which individuals should consider having available. It was recognised that communication and the attitude of staff remained amongst the top cause of complaints.
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<tr>
<td>Meeting of 24 November 2015</td>
<td>15/20</td>
<td>Opportunities Relating To Quality Outcomes Framework (QOF) And Directed Enhanced Services (DES)</td>
<td>The Committee noted the content of the report and that it was to receive further reports as work progressed.</td>
<td>David Brown</td>
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<td></td>
<td>15/21</td>
<td>Ipswich Capacity Issues</td>
<td>The Committee noted the content of the report and agreed that it receive a further detailed report on long term plans once developed.</td>
<td>David Brown</td>
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<tr>
<td>Meeting of 26 January 2016</td>
<td>16/10</td>
<td>Care Quality Commission Inspections</td>
<td>The Chief Executive of Healthwatch agreed to share feedback from a forthcoming visit to the Peninsula Practice to view best practice.</td>
<td>Andy Yacoub</td>
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<td>Meeting of 22 March 2016</td>
<td>16/20</td>
<td>Primary Care Contracts/ Performance Monitoring</td>
<td>Having considered the best way of facilitating effective decision making in respect of list closure applications the Committee agreed that face to face meetings should be convened with members of the Committee being able to telephone into the meeting if necessary.</td>
<td>Caroline Procter/Jo Mael</td>
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<td></td>
<td>16/24</td>
<td>Questions from Members of the Public</td>
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<td>Jo Mael</td>
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Agenda item No. 05
Reference No. NHSE/IESCCG JCC 16-06

From: Caroline Procter, Co-Commissioning Manager, Ipswich and East Suffolk CCG

PRIMARY CARE CONTRACTS AND PERFORMANCE MONITORING

1. **Purpose**

   1.1 The purpose of this report is to provide an update to the Committee relating to;

   - List Closures
   - Local Enhanced Services (LES)
   - PMS Dashboard
   - Prime Ministers Challenge Fund Centre (GP+)

2. **List Closures**

   2.1 It was reported to the Committee at the last meeting that one practice had requested to extend their list closure and another had requested to close their list.

   2.2 An extraordinary meeting of the Joint Commissioning Committee on the 26th April agreed that the Combs Ford practice should be able to extend their list closure for a further 3 months, with the proviso that the practice work with NHS England and the CCG to create an action plan that will enable their list to reopen at the end of the 3 month period on 1st August 2016.

   2.3 At the same meeting, the Joint Commissioning Committee refused the request by Hawthorn Drive to close their patient list but instead agreed a set of actions to address their capacity issues that were acceptable to both the CCG and the Practice that would enable the practice continue to register patients.

3. **Local Enhanced Services**

   3.1 Following formal approval of the PMS Development Framework, associated Local Enhanced Services (LES) have been amended to ensure parity between contracts. Practices have continued to provide services under the existing 15/16 LES contracts whilst discussions were taking place.

   3.2 LES specifications and information have now been sent to all GP practices and work continues to collate information to inform 16/17 GP contracts. It is anticipated that all contracts will have been issued by 31st May 2016.
4. **PMS Dashboard**

4.1 The overall performance of local practices has been reviewed jointly by the CCG and NHS England. Overall the position remains good. Since the last meeting a number of the metrics have been updated and it is intended that a final Dashboard for 2015/16 will be published shortly.

4.2 Work now continues to update the dashboard in line with the amended metrics following the PMS Development Framework review.

5. **Prime Minister’s Challenge Fund Centre**

5.1 The Prime Ministers Challenge Fund was initiated to support local health economies to put in place schemes that would enable primary care to work at scale to provide general practice services in the evening and over the weekends. The Suffolk GP Federation, working with the 2 Suffolk CCGs developed a successful bid. This scheme was resourced for an initial one year period. This has recently been extended for a further year. The criteria and resourcing have been revised.

6 **Recommendation**

The Committee is invited to:

- Note the updates received

**Author:**
Caroline Procter, Co-Commissioning Manager
Agenda item No. 06
Reference No. NHSE/IESCCG 16-07

From: David Brown, Deputy Chief Operating Officer

CARE QUALITY COMMISSION (CQC)

1. Purpose

1.1 The purpose of this report is to inform the Committee about Care Quality Commission (CQC) inspections of Ipswich and East Suffolk GP practices.

2. Background

2.1 The CQC is currently in Ipswich and East Suffolk conducting inspections within GP practices.

2.2 The inspection consists of five areas:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive to people’s needs?
- Are services well-led?

2.3 The inspection assesses services provided to six population groups:

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

3. Current Status

3.1 58% of Ipswich and East Suffolk practices have now been inspected. The following practices have been examined since January 2015:

<table>
<thead>
<tr>
<th>Practice</th>
<th>Inspected Date</th>
<th>Rating</th>
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<tbody>
<tr>
<td>Stow health</td>
<td>24 February 2015</td>
<td>“Outstanding”</td>
</tr>
<tr>
<td>Orchard Street Medical Practice</td>
<td>12 March 2015</td>
<td>“Good”</td>
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<tr>
<td>Hadleigh</td>
<td>31 March 2015</td>
<td>“Good”</td>
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<tr>
<td>Leiston</td>
<td>29 October 2015</td>
<td>“Good”</td>
</tr>
<tr>
<td>Little St' Johns Street</td>
<td>29 October 2015</td>
<td>“Good”</td>
</tr>
<tr>
<td>Constable Country Practice</td>
<td>2 November 2015</td>
<td>“Good”</td>
</tr>
<tr>
<td>Peninsula GP Practice</td>
<td>2 December 2015</td>
<td>“Outstanding”</td>
</tr>
<tr>
<td>Walton GP Surgery</td>
<td>3 December 2015</td>
<td>“Good”</td>
</tr>
<tr>
<td>Needham Mk Country Practice</td>
<td>1 December 2015</td>
<td>“Requires Improvement”</td>
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</table>
Barrack Lane Medical Practice is due to be inspected on Thursday 12 May and Framlingham Medical Practice on Tuesday 17 May 2016.

The CQC’s reports to date continue to show that the quality of primary care services in Ipswich and East Suffolk is “good”. The Inspectors have not identified any whole scale areas for improvement but highlighted individual needs and opportunities for improvement.

4. **Next Steps**

4.1 It should be noted a theme has started to emerge from the latest inspections around the storage and dispensing of controlled drugs. The Head of Operations is currently working closely with the medicines management team to ensure that assistance and appropriate communications are effectively provided to GP practices.

4.2 Needham Market has been rated as “requires improvement” following their inspection in December 2015. Action plans have been put in place relating to the safe delivery of care and well-led services which were rated as “requires improvement”. The Head of Operations has begun to support and advise the practice with their action plans.

4.3 The Head of Operations continues to advise and support the practices prior to and after the CQC inspection.

4.4 The Committee will be alerted to any significant issues or concerns between meetings and will be provided with on-going analysis of learning.

5. **Recommendation**

5.1 The Committee is invited to note the CQC’s report findings to date and consider any further actions for the CCG or NHS England at this stage.

Author:
Louise Hardwick, Head of Operations
Agenda item No. 07
Reference No. NHSE/IESCCG JCC 16-08

From: Claire Pemberton, Senior Commissioning Implementation Manager

IPSWICH PRACTICES

1. Purpose

1.1 The purpose of this report is to provide an update to the Committee regarding the Challenges facing Primary Care Services in Ipswich and surrounding practices.

2. Background

2.1 General practice in Ipswich is facing a number of challenges and increased pressure due to a number of factors. The CCG are working with NHS England, the Suffolk GP Federation and the Local Medical Committee (LMC) to identify a recovery plan to support the practices within Ipswich and surrounding areas to ensure Primary Care can remain sustainable.

3. Current Position

• A Leadership and Management Support Team have been put in place to lead the Ipswich project
• An update will be taken to the Clinic Executive every week outlining progress
• Meetings have been arranged/have taken place with each Ipswich practice and a number of those on the boundary to discuss issues and potential solutions
• The Leadership and Management Team are meeting bi-weekly to discuss progress made to date
• A number of practices have bid for the Vulnerable Practice Fund and are awaiting confirmation of the amount awarded to each practice
• Two practices have informally closed their list
• The CCG have met with Ipswich Borough Council to discuss medium term developments

4. Next steps

• The next GP Training and Education Event will focus on Primary Care
• Dr Mark Shenton is to meet with Ben Gummer MP on the 2nd June 2016 to discuss how he can support practices in the Ipswich area
• NHS England to provide a local Ipswich practice with external Practice Management support
• NHS England to release the Vulnerable Practice Funds to local practices
• Clinical Executive agreed to redirect resources and instead flex this investment for transformation and to serve as a matched ‘pot’ to the Vulnerable Practice Fund
• Ensure practices within Ipswich are able to accept patients from the Syrian resettlement programme as agreed with the Home Office
• Work with other providers to reduce workload pressure on general practices in Ipswich
• Develop a work programme to draw together the actions identified through working with local practices

5. **Recommendation**

5.1 The Committee is invited to:

• Note and comment

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**Author:**
Claire Pemberton, Senior Commissioning Implementation Manager
Agenda item No. 08
Reference No. NHSE/IESCCG 16-09

From: Caroline Procter, Co-Commissioning Manager, Ipswich and East Suffolk CCG

PRIMARY CARE TRANSFORMATION FUND

1. Purpose

1.1 The purpose of this report is to update the Committee on progress in relation to the Primary Care Transformation Fund

2. Background

2.1 NHS England announced that the £250m per year Primary Care Transformation Fund will be prioritised locally by CCGs prior to being processed by NHS England. The fund is to be used for estates and IT. The national guidance on how these monies are to be utilised was delayed by several months. In the interim Ipswich and East Suffolk CCG wrote to practices advising them to start planning schemes that they may wish to develop. A range of criteria, identified by NHS England were circulated to inform the planning in practices

2.2 At the last meeting of the Joint Commissioning Committee it was reported that a final list of prioritised schemes would be subject to ratification of this committee.

3. Current Position

3.1 The CCG received 32 bids for funding by the 1st May deadline

3.2 Guidance from NHS England has since been published. A summary of changes as follows;
   - The scheme has been renamed the Estates and Technology Transformation Fund
   - The estimated overall total of capital investment in general practice over the next five years will be over £900 million
   - No further national round of submissions will be offered
   - CCGs will need to support the revenue consequences of any scheme
   - Funding can be up to 100 percent of the costs of premises developments
   - Deliverable within financial years April 2016 to March 2019

3.3 The CCG are processing the bids in according with the criteria published by NHS England and will prioritise each bid following a stringent technical review by representatives from Finance, I.T, CCG Redesign teams, NHS England and the Local Medical Committee (LMC).

3.4 Due to the delay in receiving the technical guidance it has not been possible to present the list of bids to this Committee at this meeting
3.5 The CCG will work to ensure that a submission is made to NHS England by 30\textsuperscript{th} June following ratification by the Joint Commissioning Committee.

4. **Next steps**

4.1 In light of the above, it is proposed that the following course of action is taken:

4.1.1 That a further meeting of the Joint Commissioning Committee is arranged for June 2016 following final prioritisation by the CCG, to ratify the Framework.

5. **Recommendation**

5.1 The Committee is invited to note the above and endorse the proposed course of action.

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Author:
Caroline Procter, Co-Commissioning Manager
PERSONAL MEDICAL SERVICES DEVELOPMENT FRAMEWORK

1. **Purpose**

   1.1 The purpose of this report is to update the Committee on progress made with the Personal Medical Services (PMS) development framework

2. **Background**

   2.1 The CCG working with local practices, the Suffolk Local Medical Committee (LMC), West Suffolk CCG and NHS England revise the Framework on an annual basis

   2.2 At its last meeting on 22nd March 2016, the Committee were informed of the requirement, that in accordance with the existing Suffolk PMS Agreement, there was a contractual requirement for a ‘PMS Agreement Review Committee’ (PARC) to meet and consider/agree any changes to the Development Framework

3. **Current Position**

   3.1 The LMC identified some issues in respect of the proposed Framework changes, mainly relating to the area of prescribing. Representatives from the Ipswich and East Suffolk CCG, NHS England and the LMC met at the PARC meeting on 27th April 2016 to discuss the outstanding elements of the Framework.

   3.2 Joint agreement was reached and the PMS Framework 2016/17 approved

   3.2 The Framework has been published and distributed to all PMS practices with the caveat that the Framework is subject to ratification by the Joint Commissioning Committee

4. **Next steps**

   4.1 In the light of the above, it is proposed that the following course of action is taken:

   4.1.1 The Joint Commissioning Committee review and ratify the changes to the Framework

5. **Recommendation**

   5.1 Members of the Committee are invited to note the above and ratify the revised PMS Development Framework.

Author:  
Caroline Procter, Co-Commissioning Manager
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<td>CORE INDICATORS</td>
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<td>Access</td>
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<tr>
<td>DEVELOPMENTAL INDICATORS</td>
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<td>Access</td>
<td>7</td>
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<tr>
<td>Public health</td>
<td>8</td>
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<tr>
<td>Prescribing and medicines management</td>
<td>10</td>
</tr>
<tr>
<td>Use of NHS resources</td>
<td>12</td>
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<tr>
<td>Collaboration</td>
<td>14</td>
</tr>
<tr>
<td>Others</td>
<td>16</td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

General practice in Suffolk provides high quality care to its patients. A number of indicators are set by NHS England, the Care Quality Commission and CCGs for local services to measure standards of care and provide reassurance to patients and commissioners of consistent, high quality care. This Framework aims to bring these indicators and target outcomes together in one place. It then describes the way in which: progress is monitored; support is provided and challenge is given, where progress is not evident. The process by which disputes between commissioners and practices can be resolved, if they arise, is covered in Schedule 13 of the PMS Contract.

**The Framework**

The Framework was originally produced in Liverpool. It was then modified for use in Essex and subsequently adapted in Suffolk to provide the bedrock of a mature commissioning model, enabling delivery of high quality primary care in Suffolk. The Framework takes account of the statutory requirements of the GMS Contract, the General Medical Council’s (GMC) Good Medical Practice and the new national standards which are mandatory for all providers of health care including GP practices.

The Framework is intended not to be onerous for practices. Commissioners are committed to working closely together with practices and the Local Medical Committee (LMC) to ensure that the Framework is a user-friendly and useful tool.

The indicators included within this document are separated into two sections, ‘Core and Developmental Indicators’. The Core indicators are focused solely on access and are mandatory. The Developmental Indicators are those which practices are required to work towards. Collectively these indicators are the enablers of drivers of continuous improvement in the quality of primary care services to patients and of a stable, integrated health care system.

The indicators were initially reviewed on an annual basis but this has not taken place over the last three years as commissioning arrangements have been in transition. This refreshed version takes account of changes in commissioning arrangements and national requirements for primary care. It has been reviewed by the LMC PMS Review Committee to ensure that it is relevant and reasonable.

**Monitoring progress against the Development Framework**
The Framework is developmental and allows practices and commissioners to performance manage the new contractual arrangements in a supportive and structured way. The Development Framework includes a number of different types of metrics or progress measures. As many as possible have been designed to enable commissioners to collect monitoring data using national or local tools i.e. not requiring new or separate reporting by practices. These include, for example, national patient survey results, prescribing spend, QOF reported exception levels and local enhanced service monitoring returns, as already required by those service specifications. For a small number of other metrics a dedicated submission is required. These include, for example, a plan for how a practice will progress over time towards national public health targets and a plan for collaborating with other local practices including any support from commissioners, which may be required to achieve this.

Where an audit is referred to this means an active cycle by which clinical and operational practice is monitored and evaluated against specific criteria and any action is identified and implemented accordingly.

Where an action plan is referred to this means a live plan with specific measurable steps and associated timescales and responsibilities to achieve an objective.

Each practice’s progress against all metrics will be collated and made available to each practice individually and to all practices within a CCG area.

**Support to Practices**

The Framework is intended to support practices to put in place systems which enable quality assurance of their services and promote quality improvement and enhanced patient safety. Where a practice is experiencing challenges in progressing against the metrics, the commissioners will discuss this with the practice and identify and prioritise any additional resources, facilitation, technical or educational support required in a consistent way.

**Performance management procedures**

Should a serious or sustained concern about performance arise and the practice fails to engage with the support provided, this will be dealt with through performance management procedures that are in line with professional standards and contractual regulations.

**Dispute resolution**

The process for local dispute resolution of primary care contracts remains the same as per schedule 13 of the PMS contract.
## 1 ACCESS

<table>
<thead>
<tr>
<th>Ref</th>
<th>Applicable CCG</th>
<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
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</table>
| 1.1 | Both           | The contractor ensures the practice premises are open at all times during Core Hours, and that the practice reception is staffed at all times during Core Hours, to enable patients to make appointments and access repeat prescriptions and that a duty doctor is available, with a registered health professional available on site at all times during Core Hours. A Contractor may not sub-contract call handling during core hours without the prior written consent of NHS England, such consent only being provided in exceptional circumstances. Where a Contractor provides services from various premises, the Contractor and NHS England shall agree which premises addresses must comply with this clause. All other variations to core hours as defined above must be agreed with NHS England prior to their implementation. Where a Contractor wishes to close the premises for training purposes, such times and dates shall be agreed between the Contractor and NHS England at least 14 days prior to the planned closure. Where a contractor is unable to comply with this clause due to unforeseen circumstances including but not limited to staff sickness, the Contractor shall notify NHS England as soon as it becomes aware of the failure to open, and shall take all reasonable endeavours to secure the opening of the premises as soon as possible thereafter, including providing NHS England with access to open the premises in the absence of the Contractor.  
*Updated extract from clause 27A*                                                                 |                |
DEVELOPMENTAL INDICATORS
## ACCESS

<table>
<thead>
<tr>
<th>Ref</th>
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<td>Both West East</td>
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<tr>
<td>Ref</td>
<td>Applicable CCG</td>
<td>Indicator/Requirement</td>
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</tr>
<tr>
<td>1.1</td>
<td>Both</td>
<td>Patients should have timely access to a registered health professional, either by phone, in person or via other mediums for advice, care, treatment or onward referral.</td>
<td>National patient survey – England average for the previous quarter for the indicators below:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. The practice reception staff have been trained and are aware of the access standards</td>
<td>Q3 Ease of getting through on the phone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. The practice contacts the commissioner where there may be difficulties in achieving the standards</td>
<td>Q4 Helpfulness of reception</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. The practice has contingency plans for sustaining access standards</td>
<td>Q12 Able to get an appointment</td>
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<tr>
<td></td>
<td></td>
<td>d. The practice ensures that patients are aware of the access standards</td>
<td>Q18 Experience of making an appointment</td>
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<td></td>
<td></td>
<td>e. The practices advertises to patients that minor injury services are provided at the practice</td>
<td>Q25 Satisfaction with opening hours</td>
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<td></td>
<td></td>
<td>f. Attendance at out of hours providers of registered patients is within average range for Suffolk practices</td>
<td>Q28 Overall experience of GP surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The aggregate annual rate of attendance at and A&amp;E for the registered practice population is less than or reducing towards 15.5% (2015/16 average Suffolk rate)</td>
</tr>
</tbody>
</table>
### 2 PUBLIC HEALTH

<table>
<thead>
<tr>
<th>Ref</th>
<th>Applicable CCG</th>
<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Both West East</td>
<td></td>
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</tr>
<tr>
<td>2.1</td>
<td>Both</td>
<td><strong>SMOKING PREVALENCE</strong></td>
<td>The practice has a plan in place to show how it will contribute to reducing the prevalence of smoking of registered patients, describing the practical actions to be taken.</td>
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<tr>
<td>2.2</td>
<td>Both</td>
<td><strong>INFLUENZA VACCINATION</strong></td>
<td>The practice has a plan to achieve the minimum 75% uptake of patients over 65; 75% for pregnant women; and the Area Team target of 60% for children</td>
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<tr>
<td>2.3</td>
<td>Both</td>
<td><strong>CERVICAL SCREENING RATES</strong></td>
<td>The practice has a plan in place to achieve 80% smear uptake in line with the national target.</td>
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<tr>
<td>2.4</td>
<td>Both</td>
<td><strong>CHILDHOOD IMMUNISATION RATES</strong></td>
<td>The practice has a plan in place to achieve 90% uptake for all childhood immunisations.</td>
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<td>Ref</td>
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<tr>
<td>2.5</td>
<td>Both</td>
<td>BREAST FEEDING</td>
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<td></td>
<td>Work with local partners to increase the initiation rates for breast feeding and in particular encouraging mothers to continue breast feeding of babies</td>
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<td>2.6</td>
<td>Both</td>
<td>CHLAMYDIA SCREENING</td>
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<td></td>
<td>Practice staff encourage uptake of chlamydia screening to patients aged 24 and under: when giving contraceptive advice; by offering the test annually; and offering the test appropriately on other occasions.</td>
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<tr>
<td>2.7</td>
<td>Both</td>
<td>Obesity</td>
<td>Number of referrals per annum</td>
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<td></td>
<td>The practice refers appropriate patients to the weight management service.</td>
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</table>

**MEDICINES MANAGEMENT** – The funding for this is included in the PMS baseline
<table>
<thead>
<tr>
<th>Ref</th>
<th>Applicable CCG – Both; West; East</th>
<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
</tr>
</thead>
</table>
| 3.1 | East                             | **LEADERSHIP FOR MEDICINES MANAGEMENT**  
- Prescribing lead (or other GP representative) attends CCG prescribing lead meeting held every four months  
- At least one prescribing clerk or dispensary team to attend each of the four CCG tailored training sessions per year, to be held during training and education events  
- At least one practice nurse representative to attend two CCG training sessions per year  
- Prescribing lead (or other GP representative) meets with CCG medicines management technician monthly to discuss practice prescribing and switch work. | Attendance rates  
CCG technician to confirm monthly meetings arranged and attended by GP (or other GP representative) |
| 3.2 | East                             | **FORMULARIES, GUIDANCE, TRAFFIC LIGHT SYSTEMS**  
Practice prescribes in line with CCG formularies including Suffolk antibiotic formulary, guidance and traffic light system including shared care and hospital only drugs. | ePACT prescribing data |
| 3.3 | East                             | **BUDGET**  
Achievement of prescribing budget  
The practice uses the CCG support tool of choice where operable; i.e. Optimise Rx in Ipswich and East Suffolk | Practice to submit prescribing plan to meet budget by 1<sup>st</sup> June 2016  
The Practice meets budget  
Acceptance rate of cost saving recommendations is at or above 30% |
| 3.4 | East                             | **Antibiotics**  
To work to reduce the number of antibiotics prescribed in practice to <1.099 antibacterial items/Specific Therapeutic group Age Sex Related Prescribing Unit (STAR-PUs)  
To work to reduce the number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of antibiotics | ePACT prescribing data |
### WEST

<table>
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<tr>
<th>Ref</th>
<th>Applicable CCG – Both; West; East</th>
<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
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<tr>
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<tr>
<td></td>
<td>prescribed in practice to 10.2%</td>
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</tbody>
</table>

#### 3.1 West

**LEADERSHIP FOR MEDICINES MANAGEMENT**
Prescribing lead (or other GP representative) to attend all WSCCG prescribing leads meetings. These meetings will be held no more frequently than every four months.

**Metric/outcome**
- Attendance rates

#### 3.2 West

**PRESCRIBING BUDGET**
The practice to monitor spend against budget each month and to be proactive in implementing cost effective prescribing initiatives.

**Metric/outcome**
- Total variance (overspend) for 2016-2017 to be ≤5%

#### 3.3 West

**PRESCRIBING SUPPORT TOOL**
The practice to use ScriptSwitch and to accept the recommendations whenever possible.

**Metric/outcome**
- There is no metric associated with this indicator.
- However, practices may be challenged where routine monitoring of ScriptSwitch reports highlights inappropriate rejection of cost effective prescribing choices.

#### 3.4 West

**FORMULARIES, GUIDANCE AND TRAFFIC LIGHT SYSTEM**
The practice to adhere to WSCCG formularies, guidance and traffic

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<tr>
<th>Ref</th>
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<th>Metric/outcome</th>
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<tr>
<td></td>
<td>light system.</td>
<td></td>
<td>There is no metric associated with this indicator. However, practices may be challenged where inappropriate prescribing is evident.</td>
</tr>
<tr>
<td>3.5</td>
<td>West</td>
<td><strong>GLUTEN FREE (GF) POLICY</strong>&lt;br&gt;The practice to adhere to the revised WSCCG GF policy (February 2016).</td>
<td>Total spend on prescribed GF food to be reduced by ≥60% compared to the previous year.</td>
</tr>
<tr>
<td>3.6</td>
<td>West</td>
<td><strong>SELF CARE</strong>&lt;br&gt;The practice to monitor prescribing of medicines for the treatment of minor conditions which are available to buy over the counter, for example analgesics for minor conditions and antihistamines for hay fever. The practice to be proactive in promoting the WSCCG self care campaign: Think Pharmacist.</td>
<td>Total spend on self care drugs to be reduced by ≥10% compared to the previous year.</td>
</tr>
<tr>
<td>3.7</td>
<td>West</td>
<td><strong>GENERICS</strong>&lt;br&gt;The practice to prescribe generically where clinically appropriate and not to prescribe the following brands:&lt;br&gt;&lt;&lt;Top brands that continue to be prescribed in West Suffolk, yet could be safely and appropriately switched to the equivalent generic, will be listed&gt;&gt;</td>
<td>≥99% of the listed branded drug items to be prescribed as the generic equivalent.</td>
</tr>
<tr>
<td>Ref</td>
<td>Applicable CCG – Both; West; East</td>
<td>Indicator/Requirement</td>
<td>Metric/outcome</td>
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</table>
| 3.8 | West                             | INHALER DEVICES FOR COPD AND ASTHMA  
The practice to select cost effective inhaler devices and to step down treatment as appropriate. The practice to be proactive in using the WSCCG/WSFT guidelines on the management of COPD and asthma, along with the inhaler device cost comparators. | Total spend on all inhaler devices to be reduced by $\geq10\%$ compared to the previous year. |

### 4 USE OF NHS RESOURCES
<table>
<thead>
<tr>
<th>Ref</th>
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<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
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<tbody>
<tr>
<td>4.1</td>
<td>East</td>
<td><strong>REFERRALS</strong>&lt;br&gt;Practices should use the ALL (Advice Letter Listing) system (where possible) or equivalent system and E-referrals (replacement for Choose &amp; Book), or electronic referral methods via the clinical systems. This can be done either directly or indirectly.&lt;br&gt;The practice is working to increase the number of referrals made through Advice Letter Listing (ALL) or equivalent and meet clinical referral criteria / guidelines&lt;br&gt;In practice referral meetings to be encouraged.</td>
<td>Practices have systems in place for reporting problems with the ALL or equivalent process&lt;br&gt;90% of eligible referrals should be sent via the ALL or equivalent process</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>As an indicator of good practice, referral letters should be generated within five working days of the decision to refer a patient where ever possible (arrangements are in place to ensure that referral letters are not delayed by flexible working or planned leave). 2ww referrals sent within 24 hours&lt;br&gt;The practice implements and uses Map of Medicine or equivalent guidelines contained within them.</td>
<td>Utilisation of Map of Medicine rates will be shared with practices</td>
</tr>
<tr>
<td>4.2</td>
<td>Both</td>
<td><strong>UTILISATION OF SECONDARY CARE</strong>&lt;br&gt;The practice regularly reviews secondary care activity data through mechanisms including peer review to ensure that patients receive the optimum care in the right setting. The review should include:&lt;br&gt;• non-elective admissions&lt;br&gt;• A&amp;E attendances&lt;br&gt;• elective admissions&lt;br&gt;• diagnostics&lt;br&gt;• Outpatient referrals</td>
<td>Practice is in line with Suffolk average rates for the weighted population&lt;br&gt;• 2015/16&lt;br&gt;• Practice referral leads show evidence of oversight over practice referral systems&lt;br&gt;• Practices show evidence of clinical audit of referral to special SMS as defined by referral meetings</td>
</tr>
<tr>
<td>Ref</td>
<td>Key Applicable CCG: Both; West; East</td>
<td>Indicator/Requirement</td>
<td>Metric/outcome</td>
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<tr>
<td>4.3</td>
<td>Both</td>
<td>IT INITIATIVES</td>
<td>CCG – GP IT Agreement</td>
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<td></td>
<td></td>
<td>Practice commits to fulfil its responsibilities within the CCG-GP IT Agreement</td>
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<td>Practices will ensure they work with the CCG IT Team when planning and implementing practice specific technologies.</td>
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<td>4.4</td>
<td>Both</td>
<td>DIRECTED ENHANCED SERVICES AND ‘LOCAL ENHANCED SERVICES’</td>
<td>Directed Enhanced Services and local Enhanced Service agreements in place</td>
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<td></td>
<td>Practices will take up and deliver against any reasonable offer made by the NHS England, the CCGs or Public Health England OR explain why this is not appropriate and working with the Commissioners and other organisations to make the services available to their patients and then signpost their patients accordingly</td>
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<td>4.5</td>
<td>West</td>
<td>LOW PRIORITY PROCEDURES (LPP)</td>
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<td>The practice will ensure that all LPP requested are accompanied by the relevant T form, following a discussion between the patient and referring GP.</td>
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<tr>
<td>4.6</td>
<td>Both</td>
<td>EXCEPTION REPORTING</td>
<td>Reported exception levels compared to England average taken from the previous year i.e. 2015/16</td>
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<td></td>
<td></td>
<td>All practices will achieve an exception reporting (QOF) figure at or below the England average for all criteria unless the practice can demonstrate a local justification.</td>
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<tr>
<td>4.7</td>
<td>West</td>
<td>MINOR INJURY</td>
<td>Practice to send monthly minor injury register to the CCG with their monthly invoice for local ES injury categories would be expanded from one whole figure to Lacerations, stitches, minor trauma (a,m,l,c,g,e) significant bruising (b) non-penetrating superficial ocular foreign</td>
</tr>
<tr>
<td>Ref</td>
<td>Key Applicable CCG: Both; West; East</td>
<td>Indicator/Requirement</td>
<td>Metric OUTCOME</td>
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<td>(a) lacerations capable of closure by simple techniques (stripping, gluing, suturing) (b) significant bruises (c) minor dislocations of phalanges (d) non-penetrating superficial ocular foreign bodies (e) following advice to attend specifically given by a general practitioner or other health care professional following recent injury of a severity not amenable to simple domestic first aid (g) following recent injury where it is suspected stitches may be required (h) following blows to the head where there has been no loss of consciousness (i) recent eye injury which may include a foreign body (j) partial thickness thermal burns or scalds involving broken skin not involving the hands, feet, face, neck, genital areas (l) foreign bodies superficially embedded in tissues (m) minor trauma to hands, limbs or feet requiring dressings/other treatments.</td>
<td>bodies (d,l, h) burns (j)</td>
</tr>
</tbody>
</table>

Services need to be accessible, appropriate and sensitive to the needs of all service users. No-one should be excluded or experience particular difficulty in accessing and effectively using this service due to their race, gender, disability, sexual orientation, religion and/or age.

Practices are required to advertise this local enhanced service to their patients, within the practice leaflet and/or within the surgery. This service will fund:

- **Initial triage** including immediately necessary clinical action to staunch haemorrhage and prevent further exacerbation of the injury
- **History taking, relevant clinical examination, documentation**
- **Wound assessment** to ascertain suitability for locally based treatment and immediate wound dressing and toilet
<table>
<thead>
<tr>
<th>Ref</th>
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<tr>
<td></td>
<td>where indicated</td>
<td>(d) appropriate and timely referral and/or follow up arrangements</td>
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<td></td>
<td></td>
<td>(e) adequate facilities including premises and equipment, as are necessary to enable the proper provision of minor injury services including facilities for cardiopulmonary resuscitation</td>
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<td></td>
<td>(f) registered nurses. To provide treatment and support to patients undergoing minor injury services.</td>
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<td></td>
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<td>(g) maintenance of infection control standards.</td>
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<td></td>
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<td>(h) maintenance of records of all procedures</td>
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<td></td>
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<td>(i) peer review of minor injury activity should be conducted at regular intervals.</td>
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<td></td>
<td>Patients in the following categories may not be appropriate for treatment by the Minor Injury Service but the enhanced service covers the appropriate referral of these patients elsewhere provided the practice team triages or makes an assessment of the patient:</td>
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<tr>
<td></td>
<td>(a) any patient who cannot be discharged home after treatment</td>
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<td></td>
<td>(b) any patient with airway, breathing, circulatory or neurological compromise</td>
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<td>(c) actual or suspected overdose</td>
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<td></td>
<td>(d) accidental ingestion, poisoning, fume or smoke inhalation</td>
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<td>(e) blows to the head with loss of consciousness or extremes of age</td>
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<td>(f) sudden collapse or fall in a public place</td>
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<td>(g) penetrating eye injury</td>
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<td>(h) chemical, biological, or radioactive contamination injured patients</td>
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<tr>
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<td>(i) full thickness burns</td>
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<td>(j) burns caused by electric shock</td>
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<td></td>
<td>(k) partial thickness burns over 3cm diameter or involving: (a) injuries to organs of special sense (b) injuries to the face, neck, hands, feet or genitalia</td>
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<td></td>
<td>(l) new or unexpected bleeding from any body orifice if profuse</td>
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<td>Ref</td>
<td>Key Applicable CCG: Both; West; East</td>
<td>Indicator/Requirement</td>
<td>Metric/outcome</td>
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</tbody>
</table>
|     | (m) foreign bodies impacted in bodily orifices, especially in children  
(n) foreign bodies deeply embedded in tissues  
(o) trauma to hands, limbs or feet substantially affecting function  
(p) penetrating injuries to the head, torso, abdomen  
(q) lacerating/penetrating injuries involving nerve, artery or tendon damage.  
This is not an exhaustive list but typical examples of minor injury  
Doctors and their staff providing minor injury services would be expected to:  
(a) have either current experience of provision of minor injury work, or  
(b) have current minor injury experience, or  
(c) have recent accident and emergency experience, or  
(d) have equivalent training which satisfies relevant appraisal and revalidation procedures.  
Doctors carrying out minor injury services must be competent in resuscitation and, as for other areas of clinical practice, have a responsibility for ensuring that their skills are regularly updated.  
Doctors carrying out minor injury activity should demonstrate a continuing sustained level of activity, conduct audit data and take part in appropriate educational activities.  
Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.  
Nurses assisting in minor injury procedures should be competent in resuscitation and appropriately trained and competent taking into consideration their professional accountability and the Nursing and |
<table>
<thead>
<tr>
<th>Ref</th>
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<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
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<tbody>
<tr>
<td></td>
<td>Midwifery Council (NMC) guidelines on the scope of professional practice.</td>
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</tbody>
</table>

5 COLLABORATION
<table>
<thead>
<tr>
<th>Ref</th>
<th>Applicable CCG</th>
<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>East</td>
<td>COLLABORATION WITH OTHER PRACTICES</td>
<td>Attendance by representatives from the practices at 90% of the meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practices will:</td>
<td>Development of, and engagement with a joint plan describing how practices will work together</td>
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<td></td>
<td></td>
<td>Take part in the monthly Training and Education events to ensure that members of the practice team are up to date with the latest changes in pathways and admission avoidance schemes for patients. Practice members ensure key messages are relayed to other members of the team who are unable to attend. Those attending are required to attend for the duration of the event. 50% or above, of GPs who would normally be at work at the day of the event to attend, along with 1 nurse. The practice manager (deputy or equivalent) to attend alternate Training and Education event (i.e. 5 per year)</td>
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<td></td>
<td></td>
<td>Receive and act on relevant benchmarking data provided by the CCG at locality and education meetings</td>
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<td></td>
<td></td>
<td>Attend and actively participate in locality meetings, contributing ideas and feeding back decisions and good practice to other members of the practice team</td>
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<td></td>
<td></td>
<td>Work with the local social services, healthcare providers and other partner organisations to facilitate the development and implementation of integrated neighbourhood teams building on MDTs actively identifying patients through risk stratification</td>
<td></td>
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<td></td>
<td></td>
<td>Work with the CCG and other local practices to support the implementation of the CCG primary care strategy. This includes working collectively with other practices to make primary care more sustainable including addressing the recruitment and retention issues and enabling delivery of primary care at a larger scale through enhanced joint working including approaches to sharing services and facilities which enable the transfer of care from a secondary care setting to a primary care setting, as appropriate</td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Applicable CCG</td>
<td>Indicator/Requirement</td>
<td>Metric/outcome</td>
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</table>
| 5.2 | West           | Attend and actively participate in locality meetings, contributing ideas and feeding back decisions and good practice to other members of the practice team  
Facilitate the delivery of primary care at a larger scale to develop ways of enhanced joint working, agreeing approaches to sharing services and facilities to enable the transfer of care from a secondary care setting to a primary care setting (where appropriate)  
Work with the local social services, healthcare providers and other partner organisations to facilitate the development and implementation of integrated neighbourhood teams building on Multi-Disciplinary Teams  
Work with the CCG and other local practices to support the implementation of the CCG primary care strategy. This will include working collectively with other practices in respect of addressing the recruitment issues facing general practice and supporting joint work in relation to manpower planning | |
| 5.3 | Both           | **COMMUNITY LIAISON**  
The practice will ensure:  
a. Relationships with community groups and patient participation are promoted and encouraged.  
b. There is a feedback system for users/carers e.g. suggestion box, website and other channels  
c. The practice collates patient feedback from all available sources, for example the national patient survey, Healthwatch, NHS choices and Friends and Family test | The practice publicises the contact information of the Patient Participation Group on the practice website and on the practice noticeboard.  
The practice can demonstrate that it has a system to communicate with patients (e.g. via the website, notice boards) the results of the analysis of patient feedback and any improvements that have subsequently been made. |
### 6 OTHERS

<table>
<thead>
<tr>
<th>Ref</th>
<th>Applicable CCG; Both West; East</th>
<th>Indicator/Requirement</th>
<th>Metric/outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Both</td>
<td><strong>CLINICAL PERFORMANCE</strong>&lt;br&gt;The practice will ensure that it has a system for the identification and remedy of poor performance and monitoring effectiveness through appraisals; confidential reporting systems and performance monitoring together with adherence to professional standards of the GMC - Good Medical Practice - Conduct or performance of colleagues and Fitness to Practice procedures&lt;br&gt;The practice will ensure that the principles of the Francis and Berwick reports are reflected in practice systems.</td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>Both</td>
<td><strong>HEALTH RECORDS – including reporting of IG breaches in line with HSCIC policy</strong>&lt;br&gt;The practice will ensure:&lt;br&gt;a. There is an effective policy and procedure to safeguard confidentiality and ensure compliance with statute and other guidelines&lt;br&gt;b. A Caldicott Guardian is in place&lt;br&gt;c. A Senior Information Risk Owner (SIRO) is in place</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Both</td>
<td><strong>WINTER PLANNING ARRANGEMENTS</strong>&lt;br&gt;The practice will report the development and progress of a flu plan&lt;br&gt;Practice will utilise additional winter schemes commissioned to help keep patients at home safely where possible and report any problems to escalation managers.</td>
<td>Reporting as per current process</td>
</tr>
<tr>
<td>Ref</td>
<td>Applicable CCG; Both West; East</td>
<td>Indicator/Requirement</td>
<td>Metric/outcome</td>
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<tr>
<td>6.4</td>
<td>Both</td>
<td>DISASTER PLANNING</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>a. there is a comprehensive plan in place for business recovery and the continuity of service in the event of an emergency.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>b. advice/training from the AT/CCG on planning for emergency situations is taken up.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>c. awareness of the resources available for managing responses to emergency situations and how to access these from the NHS England and/or the CCG</td>
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</table>


Agenda item No. 12
Reference No. NHSE/IESCCG JCC 16-11

From: David Brown, Deputy Chief Operating Officer

SELF CERTIFICATION PROCESS

1. **Purpose**

1.1 The purpose of this report is to provide an update to the Committee regarding the self-certification process that relates to Co-Commissioning.

2. **Background**

2.1 Since the inception of the Co-Commissioning process CCGs have been required to submit (to NHS England) a quarterly self-certification report explaining how the CCG has executed its delegated responsibilities in respect of the Out of Hours contract and primary care services. This report is signed off by the CCG Accountable Officer. A copy of the Quarter 4 Report is attached as an example of what has been submitted previously.

2.2 A recent audit report has identified the requirement for these quarterly assurance reports to be reviewed by the Co-Commissioning Committee to ensure the process is robust.

3. **Recommendation**

3.1 Members of the Committee are invited to:

- Note the requirement for the Committee to review the self-certification reports

Author:
David Brown, Deputy Chief Operating Officer
CCG Assurance Framework 2015/16
Delegated Functions - Self-certification

CCG Name or joint committee of CCGs
Ipswich & East Suffolk CCG

Quarter/year to which certification applies | Q4 2015/16

1. Assurance Level

To support ongoing dialogue, CCGs are asked to provide a self-assessment of their level of assurance for each Delegated Function (as appropriate).

<table>
<thead>
<tr>
<th>Delegated Function</th>
<th>Assurance Level</th>
<th>Change since last period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated commissioning</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>OOH commissioning</td>
<td>Assured as good</td>
<td>No change</td>
</tr>
</tbody>
</table>

2. Outcomes

Briefly describe progress in last quarter towards the objectives and benefits the CCG set out in taking on delegated functions, in particular the benefits for all groups of patients <maximum 200 words>

The co-commissioning committee has been meeting and is effectively working though a range of issues as well as looking forward to how the co-commissioning process can be utilised to ensure service provision is tailored to local needs.

3. Governance and the management of potential conflicts of interest in relation to primary care co-commissioning (this section should be completed by those CCGs which undertake joint commissioning with NHS England as well as those that have delegated commissioning arrangements)

<table>
<thead>
<tr>
<th>Have any conflicts or potential conflicts of interest arisen during the last quarter?</th>
<th>Co-commissioning</th>
<th>OOH commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>If so has the published register been updated?</th>
<th>Updated but not published</th>
<th>No</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Is there a record in each case of how the conflict of interest has or is planned to be managed?</th>
<th>Not applicable</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Please provide brief details below and include details of any exceptions during the last quarter where conflicts of interest have not been appropriately managed.
There have been 2 joint commissioning committees for co-commissioning during Q4. Declarations of interest is a standard agenda item for this meeting and 1 was declared (insert dates). Interest declared by Chair (non-voting member) as a GP within the CCG area. Declarations recorded in minutes and kept as a record but not published as the CCG only publishes interests and not when declarations are made.

4. Procurement and expiry of contracts

Briefly describe any completed procurement or contract expiry activity during the last quarter in relation the Delegated Functions and how the CCG used these to improve services for patients (and if and how patients were engaged). <maximum 250 words per Delegated Function>

N/a

<table>
<thead>
<tr>
<th>Local Incentive Schemes</th>
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<tbody>
<tr>
<td>Is the CCG offering any Local Incentive Schemes to GP practices?</td>
</tr>
<tr>
<td>Was the Local Medical Committee consulted on each new scheme?</td>
</tr>
<tr>
<td>If any of those schemes could be described as novel or contentious did the CCG seek input from any other commissioner, including NHS England, before introducing?</td>
</tr>
<tr>
<td>Do the offered Local Incentives Schemes include alternatives to national QOF or DES?</td>
</tr>
<tr>
<td>If yes, are participating GP practices still providing national data sets?</td>
</tr>
</tbody>
</table>

What evidence could be submitted (if requested) to demonstrate how each scheme offered will improve outcomes, reduce inequalities and provide value for money? <maximum 250 words for each Delegated Function>

5. Availability of services

Briefly describe any issues raised during the last quarter impacting on availability of services to patients (include if and how patients were engaged). <maximum 250 words for each Delegated Function>

No issues raised.

The introduction of GP Plus is seen as a risk to the Out of Hours providers ability to attract GPs.

<table>
<thead>
<tr>
<th>Delegated commissioning</th>
<th>OOH commissioning</th>
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<tbody>
<tr>
<td>How many providers are currently identified by the CCG for review for contractual underperformance?</td>
<td>0</td>
</tr>
<tr>
<td>And of those providers, how many have been</td>
<td>0</td>
</tr>
<tr>
<td>Question</td>
<td>No</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>During the last quarter were any providers placed into special measures following CQC assessment?</td>
<td></td>
</tr>
<tr>
<td>If yes, please provide brief details of each case and how the CCG is supporting remediation of providers in special measures &lt;maximum 50 words per case&gt;</td>
<td></td>
</tr>
<tr>
<td>In the last 12 months has the CCG published benchmarked results of providers OOH performance (including Patient experience)</td>
<td>No</td>
</tr>
<tr>
<td>If yes, please provide link to published results:</td>
<td></td>
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</table>

6. **Internal audit recommendations**

<table>
<thead>
<tr>
<th>Delegated Function</th>
<th>Co-commissioning</th>
<th>OOH commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has internal audit reviewed your processes for completing this self-certification since the last return?</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

If so, what was their conclusion and recommendations for improvement? <maximum 200 words for each Delegated Function>

Use this space to detail any other issues or highlight any exemplar practice supporting assurance as outstanding
7. CCG declaration

I hereby confirm that the CCG has completed this self-certification accurately using the most up to date information available and the CCG has not knowingly withheld any information or misreported any content that would otherwise be relevant to NHS England assurance of the Delegated Functions undertaken by the CCG.

I confirm that the primary medical services commissioning committee remains constituted in line with statutory guidance.

I additionally confirm that the CCG has in place robust conflicts of interest processes which comply with the CCG’s statutory duties set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012), and the NHS England statutory guidance on managing conflicts of interest.

Signed by
Julian Herbert
CCG Accountable Officer

Name: Julian Herbert
Position: Chief Accountable Officer
Date: 13/1/16

Signed by
Graham Leaf
Audit Committee Chair

Name: Graham Leaf
Position: Audit Committee Chair
Date: 13/1/16

Please submit this self-certification to your local NHS England team and copy to england.primarycareops@nhs.net using the email subject ‘Delegated functions self-certification.’